GROUP BENEFIT PLAN

LAWRENCE LIVERMORE NATIONAL SECURITY, LLC

Short Term Disability and Long Term Disability

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A note on capitalization in this benefits booklet:

Capitalization of the first letter of a word or phrase not normally capitalized according to the rules of standard punctuation (Weekly Earnings, for example) indicates a word or phrase that is defined in the DEFINITIONS section, or that refers back to an item found in the Schedule of Benefits.

PS-M-73

INSURER INFORMATION NOTICE

NOTICE REQUIREMENT

IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT:

STATE OF CALIFORNIA INSURANCE DEPARTMENT
CONSUMER COMMUNICATIONS BUREAU
300 SOUTH STREET, SOUTH TOWER
LOS ANGELES, CA 90013

1-800-927-HELP

THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS:

THE HARTFORD GROUP BENEFIT'S DIVISION
POLICYHOLDER SERVICES, P.O. BOX 2999
HARTFORD, CT 06104-2999
TELEPHONE: 1-800-572-9047

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
as of the Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employee of the Policyholder who is named below and who:

- is eligible for the insurance;
- becomes insured; and
- continues to be insured;

according to the terms of the Policy.

EMPLOYEE NAME:_____
SOCIAL SECURITY NUMBER:_____

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

Terence Shields, *Secretary* **Ronald R. Gendreau, *President***

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder:	LAWRENCE LIVERMORE NATIONAL SECURITY, LLC
Group Insurance Policy:	GRH-395263
Plan Effective Date:	January 1, 2010

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF MARCH 8, 2012.

This plan of Short Term Disability Insurance provides You with short term income protection if You become Disabled from a covered injury, sickness, Mental Illness, Substance Abuse or pregnancy. Where used in this contract, the term Disabled or Disability shall mean Total Disability or Partial Disability as defined in the Definitions Section of the Certificate.

Must You contribute toward the cost of coverage?
You must contribute toward the cost of coverage.

Who is eligible for coverage?
Eligible Class(es):
All Active Eligible Employees who are:
1) citizens or legal residents of the United States working in the United States, its territories or protectorates;
2) Expatriates and Third-country Nationals; and
3) citizens or legal residents of Canada, as approved by Us, living and working in Canada;

excluding:
1) graduate and undergraduate students, temporary, leased or seasonal Employees;
2) any Employee living or working in a country:
   a) subject to a sanctions program administered by the United States Treasury Office of Foreign Asset Control; or
   b) not meeting our underwriting criteria, as determined by Us and accessible to Your Employer on Our "EmployerView" online informational source; and
3) employees who work less than a minimum of 17.5 hours per week averaged over a rolling 12 month period.

Expatriate means a citizen or legal resident of the United States living and working on temporary assignment outside of the United States, its territories and protectorates.

Third-country National means a person who is a citizen of a country other than the United States who is living and working outside of the country of which he or she is a citizen.

Full-time and Part-time Employees: 17.5 hours per week averaged over a rolling 12 month period

The **Weekly Benefit** will be the lesser of:
- 70% of Your Weekly Earnings; or
- $3,462,

reduced by Other Income Benefits.

The **Maximum Duration of Benefits** for a Disability is:
- 52 week(s) if caused by Accident;
- 52 week(s) if caused by Sickness.

Benefits Commence for Disability caused by:
Option 1 (7 Day Elimination):

- Accident: on the 8th day of Disability
- Sickness: on the 8th day of Disability
- With the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program

Option 2 (30 Day Elimination):

- Accident: on the 31st day of Disability
- Sickness: on the 31st day of Disability
- With the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program

Option 3 (90 Day Elimination):

- Accident: on the 91st day of Disability
- Sickness: on the 91st day of Disability
- With the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program

Option 4 (180 Day Elimination):

- Accident: on the 181st day of Disability
- Sickness: on the 181st day of Disability
- With the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program

When will You become eligible? (Eligibility Waiting Period)
You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

When will You become eligible?
You will become eligible for coverage on either:
1. the Plan Effective Date, if You have completed the Eligibility Waiting Period; or if not
2. the date on which You complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

How do You enroll?
To enroll You must:
1. complete and sign a group insurance enrollment form which is satisfactory to us; and
2. deliver it to the Employer.

If You do not enroll within 31 days after becoming eligible, You must submit Evidence of Insurability satisfactory to us.

What is Evidence of Insurability?
If You are required to submit Evidence of Insurability, You must:
1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at Your own expense.

We will then determine if You are insurable under the plan.

WHEN COVERAGE STARTS

When does Your coverage start?
If You must contribute towards the plan's cost, Your coverage will start on the date determined below:
1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 31 days after the date You are eligible; or
3. the date we approve Your Evidence of Insurability, if You are required to submit Evidence of Insurability.

DEFERRED EFFECTIVE DATE

Will coverage become effective if a disabling condition causes You to be absent from work on the date it is to start?
If You are absent from work due to Your:
1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date Your insurance or increase in coverage would otherwise have become effective, the effective date of the coverage or increase in coverage will be deferred until You have been Actively at Work for one full work-day.

CHANGES IN COVERAGE

Do coverage amounts change if there is a change in Your class or Your rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Weekly Earnings. However, no increase in coverage will be effective unless on that date You:
1. are an Active Full-time or Part-time Employee; and
2. are not absent from work due to Your being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Weekly Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the Plan?
Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, except that the limitations on increases stated in the Deferred Effective Date provision will apply.

BENEFITS

How do benefits become payable for Total Disability?
If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of Other Income Benefits You receive as described in the Definitions section of this Policy. The amount of Your Weekly Benefit may also be reduced by certain benefits You could reasonably be expected to receive but for which You did not apply as described in the Definitions Section of the Policy. The Weekly Benefit will also be reduced by Your Current Weekly Earnings as described in the Partial Disability section of the Policy.

See the Schedule of Insurance for the Weekly Benefit, the Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless you are under the care of a Physician other than yourself.

Loss of License: Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation alone, does not mean that You are Disabled. However, information relating to Your loss of license supporting Your claim for benefits may be submitted as part of Your proof of Loss.

How is a benefit calculated for a period of less than a week?
If a Weekly Benefit is payable for less than a week, we will pay 1/7 of the Weekly Benefit for each day you were Disabled.

PARTIAL DISABILITY BENEFITS

How are benefits paid for Partial Disability?
If while covered under this benefit, You become Disabled and work on a part-time or limited duty basis because You are Partially Disabled, for the first 12 months of a return to work, We will reduce Your Weekly Benefit by Current Weekly Earnings only to the extent that such earnings when added to the Weekly Benefit payable exceed 100% of Your weekly Pre-disability Earnings.

How are benefits calculated after twelve months of benefits have been paid?
After the first 12 month period of any Partial Disability and for any remaining or additional periods of Partial Disability, Your Weekly Benefit will be calculated as follows:

1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
2) Compare the result with the Maximum Benefit; and
3) From the lesser amount, deduct Other Income Benefits and 50% of Your Current Weekly Earnings.

The result is Your Weekly Benefit.

If you are participating in a program of Rehabilitative Employment, your Weekly Benefit will be determined by the Rehabilitative Employment Benefit.

How is a benefit calculated for a period of less than a week?
If a Weekly Benefit is payable for less than a week, we will pay 1/7 of the Weekly Benefit for each day you were Disabled.

When will benefit payments cease?
Benefit payments will stop on the first to occur of:
1. the date you are no longer Disabled;
2. the date you fail to furnish proof that you continue to be Disabled;
3. the date you refuse to be examined, if we require an examination;
4. the last day benefits are payable according to the Maximum Duration of Benefits shown in the Schedule of Insurance; or
5. the date you die.

RECURRENT DISABILITY

What happens to your benefits if you return to work as an Active Full-time or Part-time Employee and then become Disabled again?
If you return to work as an Active Full-time or Part-time Employee for 30 consecutive days or more, any recurrence of a disability will be treated as a new Disability with respect to when Benefits Commence and the Maximum Duration of Benefits, as shown in the Schedule of Insurance.

If recurrent periods of Disability are:
1. due to the same or a related cause; and
2. separated by less than 30 consecutive days of work as an Active Full-time or Part-time Employee,

they will be considered to be the same period of Disability.

MULTIPLE CAUSES

How long will benefits be paid if a period of Disability is extended by another cause?
If a period of Disability is extended by a new cause while weekly benefits are payable, weekly benefits will continue while you remain Disabled, subject to the following:
1. weekly benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2. the Exclusions will apply to the new cause of Disability.

VOCATIONAL REHABILITATION

What is Vocational Rehabilitation? Vocational Rehabilitation means employment or services that prepare You, if Disabled, to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:
1. vocational testing;
2. vocational training;
3. work-place modification;
4. prosthesis; or
5. job placement.

REHABILITATIVE EMPLOYMENT

Rehabilitative Employment means employment that is part of a program of Vocational Rehabilitation.

Do earnings from Rehabilitative Employment affect the Weekly Benefit?
If You are Disabled and are engaged in an approved program of Rehabilitative Employment, for the first 12 months that benefits are payable under this provision We will reduce Your Weekly Benefit by Your Current Weekly Earnings only to the extent that such earnings when added to the Weekly Benefit payable exceed 100% of Your weekly Pre-disability Earnings.

After 12 months of benefits have been paid under this provision and for any additional period of Rehabilitative Employment Your Weekly Benefit will be:
1. the amount calculated for Total Disability; but
2. reduced by 50% of the income received from each week of such Rehabilitative Employment.

The sum of Your Weekly Benefit and total income received under this provision may not exceed 100% of Your weekly Indexed Pre-disability Earnings. If this sum exceeds Your weekly Indexed Pre-disability Earnings, the Weekly Benefit paid by us will be reduced proportionately.

EXCLUSIONS

What Disabilities are not covered?
The plan does not cover, and no benefit shall be paid for, any:
1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation; or
4. Disability caused or contributed to by an intentionally self-inflicted injury.

If You are receiving, or are eligible to receive, benefits for a Disability under a prior plan of disability benefits that:
1. was sponsored by the Employer; and
2. was terminated on the day before the Effective Date of this plan,

then no benefits will be payable for the Disability under this plan.

TERMINATION

When does Your insurance terminate?
Your insurance will terminate on the earliest of:
1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures Your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which You make any required premium contribution, if You fail to make any further required contribution;
5. the date on which You cease to be an Active Full-time or Part-time Employee in an eligible class, including:
   a) temporary layoff;
   b) leave of absence; or
   c) work stoppage (including a strike or lockout); or
   d) the date Your Employer ceases to be a Participant Employer, if applicable.

Is there a state law requiring coverage be continued during a family care or medical leave of absence?
You may be entitled to continue Your coverage for up to 12 weeks during any 12 month period if You are absent from Active Full-time or Part-time work due to a family care or medical leave of absence under the provisions of the California Family Care and Medical Leave Act. During such period, Your coverage may be continued according to a plan established by Your employer. Please contact Your employer for further information on Your right to continued coverage during a family care or medical leave of absence.

May coverage be continued during a leave of absence?
If You are granted a leave of absence, Your Employer may continue Your insurance as defined in the Employer's Leave Policy, subject to the following:
1. the leave authorization must be in writing, or must be documented as a leave for military purposes;
2. the required premium for You must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the termination of the Group Insurance Policy;
   c) non-payment of premium when due by the Policyholder or You;
   d) the Group Insurance Policy no longer insures Your class; or
   e) the date Your Employer ceases to be a Participant Employer, if applicable.

Does Your insurance continue while You are Disabled and no longer an Active Full-time or Part-time Employee?
If You are no longer an Active Full-time or Part-time Employee because You are Disabled, Your Short Term Disability Insurance will be continued:
1. while You remain Disabled;
2. without payment of premium after the date we receive written notice of claim; and
3. until the end of the period for which You are entitled to receive Short Term Disability Benefits.

After Short Term Disability benefit payments have ceased, Your insurance will be reinstated, provided:
1. You return to work for one full day as an Active Full-time or Part-time Employee in an eligible class;
2. the Group Insurance Policy remains in force; and
3. the required premium is paid.

Do benefits continue if the Group Insurance Policy terminates?
If You are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:
1. will continue as long as You remain Disabled by the same disabling condition; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no affect on our liability under this provision.

GENERAL PROVISIONS

Time limits on Certain Defenses: What happens if facts are misstated?
After three years from the date of issue of this Policy, no misstatement of the employer, except a fraudulent misstatement made in the application shall be used to void the Policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after expiration of such three years.

Notice of Claim: When should We be notified of a claim?
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at our offices in Hartford, Connecticut, or to any of our authorized agents, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms: Are special forms required to file a claim?
We will, upon receipt of written claim notice, furnish to You such forms as are usually furnished by us for filing proof of loss. If such forms are not furnished within 15 days after We receive written notice of claim You shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss: When must proof of loss be given?
Written proof of loss must be furnished to the insurer in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Physical Examinations and Autopsy: What additional proof of Disability are We entitled to?
At Our own expense, We shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Payment of Claims: Who gets the benefit payments?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any indemnity of the policy shall be payable to Your estate or to a person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1000.00 to any relative by blood or connection by marriage of such person or beneficiary whom We deem to be equitably entitled thereto. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Time Payment of Claims: When are payment checks issued?
Indemnities payable under the policy for any loss other than loss for which the policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the policy provides periodic payment will be paid on a weekly basis and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:
1. give the specific reason(s) for the denial;
2. make specific reference to the policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any claim, the claimant or His representative must appeal to Us for a full and fair review.
1. You must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
   b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

Legal Action: When can legal action be started?
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

What are our subrogation rights?
If You:
1. suffer a Disability because of the act or omission of a third party;
2. become entitled to and are paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights You may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability.

Must You apply for Social Security Disability Benefits?
We may require that You apply for Social Security Disability Benefits if it appears that Your Disability may meet the minimum duration required to qualify for such benefits. If the Social Security Administration denies Your eligibility for any such benefits, You will be required to follow the process established by the Social Security Administration to reconsider the denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

How will We Determine Your Eligibility for Benefits?
We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits for any claim You make on The Policy. We will:

1) obtain, with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
2) consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination Your eligibility for benefits based on that information and in accordance with the Policy and applicable law;
3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with the Policy as described in the provision entitled "What notification will You receive if Your claim is denied?"

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled "What recourse do You have if Your claim is denied?" If You do not appeal the decision to Us, then the decision will be Hartford's final decision.

DEFINITIONS

The terms listed will have these meanings:

Active Full-time or Part-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. Such employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Full-time or Part-time Employment shown in the Schedule of Insurance.

Actively at Work
You will be considered to be actively at work with the Employer on a day which is one of the Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time or Part-time basis on that day. You will be deemed to be actively at work on a day which is not one of the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Current Weekly Earnings means the weekly earnings You receive from work You perform for Your Employer or for another employer with whom You became employed after Your Disability commenced.

Employer means the Policyholder.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorders, but excluding demonstrable structural brain damage.

Other Income Benefits mean the amount of any benefit for loss of income, provided to You as a result of the Disability for which You are claiming benefits under this plan. This includes any such benefits that are paid to You or to a third party on Your behalf. This includes the amount of any benefit for loss of income from:

1. the United States Social Security Act, Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that You are eligible to receive because of Your Disability;
2. the Veteran's Administration or any other governmental agency for the same Disability;
3. any governmental law or program that provides disability benefits as a result of Your job with the Employer;
4. salary continuation or sick pay;
5. the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;

6. any temporary disability benefits under a workers' compensation law, occupational disease law, or similar law.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

Any general increase in benefits required by law that You are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If You are paid Other Income Benefits in a lump sum, We will pro rate the lump sum:
1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined over a period of 26 weeks.

We may require:
1. Your signed statement identifying all Other Income Benefits; and
2. proof that You have duly applied for all Other Income Benefits We reasonably believe You are entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

You will be required to apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You will be required to apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:
1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals if such action can reasonably be expected to result in an award.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence.

If Your disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

We will use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Weekly Benefit payable under this plan even if You are not receiving these benefits.

We will use any reasonable means to estimate the amount of temporary disability benefits payable to You under a workers compensation law or any other occupational disease law or similar act; or the amount of benefits payable to You under any statutory benefit law, plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of these benefits from Your Weekly Benefit payable under this plan even if You are not receiving these benefits.

Physician means a practitioner of a healing art, which we are required by law to recognize, who is properly licensed, and practicing within the scope of that license.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Partial Disability or Partially Disabled means that You are not Totally Disabled and, while actually working in an occupation, as a result of sickness or injury You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life and physical and mental capacity.

Sickness vs. Accident
A Disability shall be deemed to be caused by sickness, and not by accident, if:
1. it is caused or contributed to by:
   a) any condition, disease or disorder of the body or mind;
   b) any infection, except a pus-forming infection of an accidental cut or wound;
   c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
   d) any disease of the heart;
   e) Mental Illness;
   f) Substance Abuse;
   g) pregnancy;
   h) any medical treatment for items (a) through (g) above; or
2. it is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means that as a result of sickness or injury You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your usual occupation in the usual or customary way.

Substantial and Material Acts means acts that are normally required for the performance of Your usual occupation and cannot be reasonably omitted or modified.

We, **us** or **our** means the Hartford Life and Accident Insurance Company.

Weekly Earnings means the weekly average of the last six pay periods from the Employer just prior to the date you became disabled, not counting:
1. commissions;
2. bonuses;
3. overtime pay; or
4. any other fringe benefit or extra compensation.

You or **your** means the insured person to whom this Booklet-certificate is issued.

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Group Long Term Disability Benefits

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INSURER INFORMATION NOTICE

NOTICE REQUIREMENT

IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT:

STATE OF CALIFORNIA INSURANCE DEPARTMENT
CONSUMER COMMUNICATIONS BUREAU
300 SOUTH STREET, SOUTH TOWER
LOS ANGELES, CA 90013

1-800-927-HELP

THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS:

THE HARTFORD GROUP BENEFIT'S DIVISION
POLICYHOLDER SERVICES, P.O. BOX 2999
HARTFORD, CT 06104-2999
TELEPHONE: 1-800-572-9047

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
as of the Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employee of the Policyholder who is named below and who:

- is eligible for the insurance;
- becomes insured; and
- continues to be insured;

according to the terms of the Policy.

EMPLOYEE NAME:_____
SOCIAL SECURITY NUMBER:_____

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

Terence Shields, *Secretary* **Ronald R. Gendreau, *President***

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder:	LAWRENCE LIVERMORE NATIONAL SECURITY, LLC
Group Insurance Policy:	GLT-395263
Plan Effective Date:	January 1, 2010

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF MARCH 8, 2012.

This plan of Long Term Disability Insurance provides You with long term income protection if You become Disabled from a covered injury, sickness, Mental Illness, Substance Abuse or pregnancy. Where used in this contract, the term Disabled or Disability shall mean Total Disability or Partial Disability as defined in the Definitions Section of the Certificate.

Must You contribute toward the cost of coverage?
You must contribute toward the cost of coverage.

Who is eligible for coverage?
Eligible Class(es):
All Active Eligible Employees who are:
1) citizens or legal residents of the United States working in the United States, its territories or protectorates;
2) Expatriates and Third-country Nationals; and
3) citizens or legal residents of Canada, as approved by Us, living and working in Canada;

excluding:
1) graduate and undergraduate students, temporary, leased or seasonal Employees; and
2) any Employee living or working in a country:
   a) subject to a sanctions program administered by the United States Treasury Office of Foreign Asset Control; or
   b) not meeting our underwriting criteria, as determined by Us and accessible to Your Employer on Our "EmployerView" online informational source; and
3) employees who work less than a minimum of 17.5 hours per week averaged over a rolling 12 month period.

Expatriate means a citizen or legal resident of the United States living and working on temporary assignment outside of the United States, its territories and protectorates.

Third-country National means a person who is a citizen of a country other than the United States who is living and working outside of the country of which he or she is a citizen.

Full-time and Part-time Employees:	17.5 hours per week averaged over a rolling 12 month period
Maximum Monthly Benefit:	$15,000
Minimum Monthly Benefit:	$100
Benefit Percentage:	50%
Secondary Benefit Percentage:	70%

When will You become eligible? (Eligibility Waiting Period)
You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

The Elimination Period is the period of time You must be Disabled before benefits become payable. It is 52 weeks from the date the Short Term Disability Benefit begins. This takes into account the choice of elimination period, number of mandatory sick days and voluntarily used days.

MAXIMUM DURATION OF BENEFITS TABLE

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

The above table shows the maximum duration for which benefits may be paid. All other limitations of the plan will apply.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

When will You become eligible?
You will become eligible for coverage on either:
1. the Plan Effective Date, if You have completed the Eligibility Waiting Period; or if not
2. the date on which You complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

How do You enroll?
To enroll You must:
1. complete and sign a group insurance enrollment form which is satisfactory to us; and
2. deliver it to the Employer.

If You do not enroll within 31 days after becoming eligible, You must submit Evidence of Insurability satisfactory to us.

What is Evidence of Insurability?
If You are required to submit Evidence of Insurability, You must:
1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at Your own expense.

We will then determine if You are insurable under the plan.

WHEN COVERAGE STARTS

When does Your coverage start?
If You must contribute towards the plan's cost, Your coverage will start on the date determined below:
1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 31 days after the date You are eligible; or
3. the date we approve Your Evidence of Insurability, if You are required to submit Evidence of Insurability.

DEFERRED EFFECTIVE DATE

When will coverage become effective if a disabling condition causes You to be absent from work on the date it is to start?
If You are absent from work due to:
1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date Your insurance or increase in coverage would otherwise have become effective, Your effective date will be deferred. Your insurance, or increase in coverage will not become effective until You are Actively at Work for one full day.

CHANGES IN COVERAGE

Do coverage amounts change if there is a change in Your class or Your rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Monthly Rate of Basic Earnings. However, no increase in coverage will be effective unless on that date You:
1. are an Active Full-time or Part-time Employee; and
2. are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Rate of Basic Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the plan?
Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, subject to the Deferred Effective Date provision.

BENEFITS

When do benefits become payable?
You will be paid a monthly benefit if:
1. You become Disabled while insured under this plan;
2. You are Disabled throughout the Elimination Period;
3. You remain Disabled beyond the Elimination Period;
4. You are, and have been during the Elimination Period, under the Regular Care of a Physician; and
5. You submit proof of loss.

Benefits accrue as of the first day after the Elimination Period and are paid monthly.

Loss of License: Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation alone, does not mean that You are Disabled. However, information relating to Your loss of license supporting Your claim for benefits may be submitted as part of Your proof of Loss.

When will benefit payments terminate?
We will terminate benefit payment on the first to occur of:
1. the date You are no longer Disabled as defined;
2. the date You fail to furnish Proof of Loss, when requested by us;
3. the date You are no longer under the Regular Care of a Physician, or refuse our request that You submit to an examination by a Physician;
4. the date You die;
5. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
6. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
7. the date You refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS

Are benefits limited for Mental Illness or Substance Abuse?
If You are Disabled because of:
1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable:
1. only for so long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when You are not so confined, a total of 36 months for all such Disabilities during Your lifetime.

SUBSTANCE ABUSE LIMITATION

Are benefits limited for alcoholism or Substance Abuse?
If You are Disabled because of:
1. alcoholism; or
2. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable for up to 36 months, provided You are:
1. confined in a hospital or other place licensed to provide medical care for the disabling condition; or

2. actively participating in a rehabilitative program approved by us.

RECURRENT DISABILITY

What happens if You return to work but become Disabled again?
Attempts to return to work as an Active Full-time or Part-time Employee during the Elimination Period will not interrupt the Elimination Period, provided no more than 30 such return-days are taken.

Any day You were Actively at Work will not count towards the Elimination Period.

After the Elimination Period, when a return to work as an Active Full-time or Part-time Employee is followed by a recurrent Disability, and such Disability is:
1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided the Group Insurance Policy remains in force.

If You return to work as an Active Full-time or Part-time Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. A new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits. The Elimination Period and Maximum Duration of Benefits Table are in the Schedule of Insurance.
The term "Period of Disability" as used in this provision means a continuous length of time during which You are Disabled under this plan.

CALCULATION OF MONTHLY BENEFIT

How are benefits calculated for Disability?
If You are Disabled after the Elimination Period, Your Monthly Benefits will be calculated as follows:
1. multiply Your Pre-disability Earnings by the Benefit Percentage shown in the Schedule of Insurance;
2. multiply Your Pre-disability Earnings by the Secondary Benefit Percentage shown in the Schedule of Insurance, and from this product subtract all Other Income Benefits;
3. identify the Maximum Benefit shown in the Schedule of Insurance; and
4. from the least of the amounts determined in items (1), (2) and (3) above, subtract Current Monthly Earnings.

The result is Your Monthly Benefit. Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

If a reduction to Your Monthly Benefit is applied for Current Monthly Earnings, we will adjust your Pre-disability Earnings for inflation annually by the percentage change in the Consumer Price Index (CPI-W) prior to taking that reduction. The adjustment will be made January 1st each year after you have been Disabled for 12 consecutive months, and if you are receiving benefits at the time the adjustment is made.

For the first 12 months that benefits are payable while working, We will only reduce Your Monthly Benefit by that amount of Your Current Monthly Earnings, which when combined with Your Monthly Benefit amount exceed 100% of Your Indexed Pre-disability Earnings. After 12 months We will subtract 50% of Your Current Monthly Earnings.

How is the benefit calculated for a period of less than a month?
If a Monthly Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day you were Disabled.

RETURN TO WORK INCENTIVE

How are benefits calculated if You return to limited duties during or following the Elimination Period?
For the first 12 months of a period of Partial Disability, Your Monthly Benefit will be calculated as follows:

1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
2) Compare the result with the Maximum Benefit; and
3) From the lesser amount, deduct Other Income Benefits.

This is Your Monthly Benefit.

Your Monthly Benefit will be reduced by the amount of Your Current Monthly Earnings, which when combined with Your Monthly Benefit amount exceed 100% of Your Indexed Pre-disability Earnings.

How are benefits calculated after the 12th Monthly Benefit has been paid?
After 12 months of benefit have been paid to You for Partial Disability and for any remaining or additional periods of Partial Disability, Your Monthly Benefit will be calculated as follows:

1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
2) Compare the result with the Maximum Benefit; and
3) From the lesser amount, deduct Other Income Benefits and 50% of Your Current Monthly Earnings.

The result is Your Monthly Benefit.

Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

How is the benefit calculated for a period of less than a month?
If a Monthly Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day you were Disabled.

Benefit Percentages and Maximum Benefits are shown in the Schedule of Insurance.

VOCATIONAL REHABILITATION/ REHABILITATIVE EMPLOYMENT

What Vocational Rehabilitative services are available?
Vocational Rehabilitation means employment or services that prepare You, if Disabled, to resume gainful work. If You are Disabled, our Vocational Rehabilitative Services may help prepare You to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:
1. vocational testing;
2. vocational training;
3. work-place modification, to the extent not otherwise provided;
4. prosthesis; or
5. job placement.

Rehabilitative Employment means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by us.

Do earnings from Rehabilitative Employment affect the Monthly Benefit?
If You are Disabled and are engaged in an approved program of Rehabilitative Employment, For the first 12 months that benefits are payable to You under this provision, the sum of Your Monthly Benefit and Your earnings received from Rehabilitative Employment may not exceed 100 % of Your Indexed Pre-disability Earnings. If it does, the Monthly Benefit will be reduced by the amount of excess. We will deduct any Other Income Benefits from the Monthly Benefit payable to You under this provision.

After 12 months of benefits have been paid under this provision, Your Monthly Benefit will be:

1. the Monthly Benefit amount payable for Total Disability; but
2. reduced by Other Income Benefits and 50% of the income received from each month of such Rehabilitative Employment

FAMILY CARE CREDIT BENEFIT

What if You must incur expenses for Family Care Services in order to participate in a program of Rehabilitative Employment?
If You are working as part of a program of Rehabilitative Employment, we will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from Rehabilitative Employment, subject to the following limitations:

1. Family Care means the care or supervision of:
   a) Your children under age 13; or
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2. the maximum monthly deduction allowed for each qualifying child or family member is:
   a) $350 during the first 12 months of Rehabilitative Employment; and
   b) $175 thereafter,
   but in no event may the deduction exceed the amount of Your monthly earnings;
3. Family Care Credits may not exceed a total of $2,500 during a calendar year;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
   a) You are no longer in a program of Rehabilitative Employment; or
   b) Family Care Credits for 24 months have been deducted during Your Disability; and
7. no Family Care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Your net earnings after deducting your Family Care Credit will be used to determine your net Monthly Benefit according to the Rehabilitative Employment provision. The sum of your net Monthly Benefit and gross income from Rehabilitative Employment, before deducting your Family Care Credit, may not exceed 100% of your Indexed Pre-disability Earnings. If it does, the net Monthly Benefit will be reduced by the amount of the excess.

SURVIVOR INCOME BENEFIT

Will Your survivors receive a benefit if You should die while receiving Disability Benefits?
If You die while receiving benefits under this plan, a Survivor Benefit will be payable to:

1. Your surviving Spouse;
2. Your surviving Child(ren), in equal shares, if there is no surviving Spouse; or
3. Your estate, if there is no surviving Spouse or Child.

If a minor Child is entitled to benefits, we may, at our option, make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The Benefit is one payment of an amount that is 3 times the lesser of:

1. Your Monthly Income Loss multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.

The following terms apply to this Benefit:
"Spouse" means Your wife or husband who:
   a) is mentally competent; and
   b) was not legally separated from You at the time of Your death.

Surviving Child(ren) includes children of Your California registered domestic partner.

With respect to California residents only, "Spouse" will include an individual who is in a registered domestic partnership with the employee in accordance with California law. Reference in this form to an employee's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

WORKPLACE MODIFICATION BENEFIT

Will our Rehabilitation program provide for modifications to the workplace to accommodate a Disabled employee's return to work?
We will reimburse Your Employer for the expense of reasonable modifications to Your workplace to accommodate Your Disability and enable You to return to work as an Active Full-time or Part-time Employee. To qualify for this benefit:

1. Your Disability must be covered by this plan;
2. the Employer must agree to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the essential duties of Your job; and
3. any proposed modifications must be approved in writing by us.

Benefits paid for such workplace modification shall not exceed the amount equal to Your Pre-disability Earnings multiplied by the Benefit Percentage.

We have the right, at our expense, to have You examined or evaluated by:

1. a physician or other health care professional; or
2. a vocational expert or rehabilitation specialist,

of our choice so that we may evaluate the appropriateness of any proposed modification.

The Employer's costs for approved modifications will be reimbursed after:

1. the proposed modifications made on Your behalf are complete;
2. we have been provided written proof of the expenses incurred to provide such modification; and
3. You have returned to work as an Active Full-time or Part-time Employee.

This Workplace Modification benefit will not be payable if:

1. the Employer does not incur any cost in making the modification;
2. we have not given written approval of the modification prior to expenses being incurred; or
3. You become self-employed, or return to work for another employer.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this plan.

PRE-EXISTING CONDITIONS LIMITATIONS

Are there any limitations on coverage?
This policy will not provide coverage for any period of Disability beginning within the first 12 months of the effective date of Your coverage under this policy if the period of Disability is caused by or substantially contributed to by a Pre-existing condition or the medical or surgical treatment of a Pre-existing condition.

You have a Pre-existing condition if:

1. You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the 3 months immediately prior to the effective date of coverage under this Policy; or
2. You suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in Your application, and:
    a. for which You received a physician's advise or treatment within 3 months before the date of Your coverage under this policy; or
    b. which caused symptoms within 3 months before the date of issue for which a prudent person would usually seek medical advice or treatment.

CONTINUITY FROM A PRIOR PLAN

Is there continuity of coverage from a Prior Plan?
If you were:
1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

If you become insured under the Group Insurance Policy on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:
1. the Plan Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the previous paragraph will be the lesser of:
1. the Monthly Benefit which was paid by the Prior Plan; or
2. the Monthly Benefit provided by this plan.

No payment shall be made after the earlier to occur of:
1. the date payments would have ceased under the Prior Plan; or
2. the date payments cease under this plan.

If you received Monthly Benefits for Disability under the Prior Plan, and:
1. you returned to work as an Active Full-time or Part-time Employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

EXCLUSIONS

What Disabilities are not covered?
The plan does not cover, and no benefit shall be paid for any Disability:
1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war (declared or not);
3. caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation;
4. caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:
1. was sponsored by the Employer; and
2. was terminated before the Effective Date of this plan,

no benefits will be payable for the Disability under this plan.

TERMINATION

When does Your coverage terminate?
You will cease to be covered on the earliest to occur of the following dates:
1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures Your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which You make any required premium contribution, if You fail to make any further required contribution;
5. the date You cease to be an Active Full-time or Part-time Employee in an eligible class including:
   a) temporary layoff;
   b) leave of absence; or
   c) a general work stoppage (including a strike or lockout); or
6. the date Your Employer ceases to be a Participant Employer, if applicable.

May coverage be continued during a leave of absence?
If You are granted a leave of absence, Your Employer may continue Your insurance as defined in the Employer's Leave Policy, subject to the following:
1. the leave authorization is in writing or is documented as a leave for military purposes;
2. the required premium must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the termination of the Group Insurance Policy;
   c) non-payment of premium when due by the Policyholder or You;
   d) the Group Insurance Policy no longer insures Your class; or
   e) Your Employer ceases to be a Participant Employer, if applicable.

Does Your coverage continue if Your employment terminates because You are Disabled?
If You are Disabled and You cease to be an Active Full-time and Part-time Employee, Your insurance will be continued:
1. during the Elimination Period while You remain Disabled by the same Disability; and
2. after the Elimination Period for as long as You are entitled to benefits under the Policy.

Must premiums be paid during a Disability?
No premium will be due for You:
1. after the Elimination Period; and
2. for as long as benefits are payable.

Do benefits continue if the plan terminates?
If You are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:
1. will continue as long as You remain Disabled by the same Disability; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no effect on our liability under this provision.

Is there a state law requiring coverage be continued during a family care or medical leave of absence?
You may be entitled to continue Your coverage for up to 12 weeks during any 12 month period if You are absent from Active Full-time or Part-time work due to a family care or medical leave of absence under the provisions of the California Family Care and Medical Leave Act. During such period, Your coverage may be continued according to a plan established by Your employer. Please contact Your employer for further information on Your right to continued coverage during a family care or medical leave of absence.

GENERAL PROVISIONS

Time Limits on Certain Defenses: What happens if facts are misstated?
After three years from the date of issue of this Policy, no misstatement of the employer, except a fraudulent misstatement made in the application shall be used to void the Policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after expiration of such three years.

No claim for loss incurred or disability (as defined in the Policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage with respect to which the claim is made.

Notice of Claim: When should We be notified of a claim?
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at our offices in Hartford, Connecticut, or to any of our authorized agents, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms: Are special forms required to file a claim?
We will, upon receipt of written claim notice, furnish to You such forms as are usually furnished by us for filing proof of loss. If such forms are not furnished within 15 days after We receive written notice of claim You shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss: When must proof of Disability be given?
Written proof of loss must be furnished to Us at our offices in Hartford, Connecticut in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Physical Examinations and Autopsy: What additional proof of Disability are We entitled to?
At our Own expense, We shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Time Payment of Claims: When are payment checks issued?
Indemnities payable under the policy for any loss other than loss for which the policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the policy provides periodic payment will be paid on a monthly basis and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Who gets the benefit payments?
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any indemnity of the policy shall be payable to Your estate or to a person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1000.00 to any relative by blood or connection by marriage of such person or beneficiary whom We deem to be equitably entitled thereto. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:
1. give the specific reason(s) for the denial;
2. make specific reference to the Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any claim, the claimant or His representative must appeal to Us for a full and fair review.
1. You must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
   b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

Legal Action: When can legal action be started?
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

What happens if benefits are overpaid?
An overpayment occurs when it is determined that the total amount we have paid in benefits is more than the amount that was due to You under the plan. This includes, but is not limited to, overpayments resulting from:
1. retroactive awards of Other Income Benefits;
2. failure to report, or late notification to us of Other Income Benefits or earned income;
3. misstatement; or
4. an error we may make.

We have the right to recover from You any amount that is an overpayment of benefits under this plan. You must refund to us the overpaid amount. We may also, without forfeiting our right to collect an overpayment through any means legally available to us, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the Minimum Monthly Benefit.

What are our subrogation rights?
If an Insured Person:
1. suffers a Disability because of the act or omission of a third party;
2. becomes entitled to and is paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. does not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time;

then we will be subrogated to any rights the Insured Person may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability.

How will We Determine Your Eligibility for Benefits?

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits for any claim You make on The Policy. We will:
1) obtain, with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other

information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;

2) consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination Your eligibility for benefits based on that information and in accordance with the Policy and applicable law;
3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with the Policy as described in the provision entitled "What notification will You receive if Your claim is denied?"

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled "What recourse do You have if Your claim is denied?" If You do not appeal the decision to Us, then the decision will be Hartford's final decision.

DEFINITIONS

The terms listed will have these meanings.

Actively at Work
You will be considered to be actively at work with your Employer on a day which is one of your Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time or Part-time basis on that day. You will be deemed to be actively at work on a day which is not one of your Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Active Full-time or Part-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours indicated in the Schedule of Insurance.

Any Occupation, if used in this Booklet-certificate, means an occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

Current Monthly Earnings means the monthly earnings You receive from work You perform for Your Employer or for another employer with whom You became employed after Your Disability commenced.

Employer means the Policyholder.

Essential Duty means the substantial and material acts that are normally required for the performance of Your Usual Occupation, which cannot reasonably be omitted or modified.

To be at work for the number of hours in Your regularly scheduled workweek is also an Essential Duty. However, to be at work in excess of 17.5 hours a week is not an Essential Duty.

Your Occupation or Your Usual Occupation, if used in this Booklet-certificate, means any employment, business, trade or profession and the substantial and material acts of the occupation You were regularly performing for Your employer when the disability began. Your Occupation is not necessarily limited to the specific job You performed for Your employer.

Indexed Pre-disability Earnings when used in this policy means Your Pre-disability Earnings adjusted annually by the percentage change in the Consumer Price Index (CPI-W).

The adjustment is made January 1st each year after You have been Disabled for 12 consecutive months, and if You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31st, and the prior year's CPI-W as of July 31st, divided by the prior year's CPI-W.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral or emotional disorders, but excluding demonstrable, structural brain damage.

Monthly Benefit means a monthly sum payable to you while you are Disabled, subject to the terms of the Group Insurance Policy.

Monthly Income Loss is the difference of your Pre-disability Earnings less your Current Monthly Earnings.

Monthly Rate of Basic Earnings means the monthly average of the last six pay periods from the Employer just prior to the date You became disabled, not counting:
1. commissions;
2. bonuses;
3. overtime pay; or
4. any other fringe benefit or extra compensation.

Other Income Benefits mean the amount of any benefit for loss of income, provided to You as a result of the Disability for which You are claiming benefits under this plan. This includes any such benefits that are paid to You or to a third party on Your behalf. This includes the amount of any benefit for loss of income from:
1. the United States Social Security Act, Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that You are eligible to receive because of Your Disability;
2. the Veteran's Administration or any other governmental agency for the same Disability;
3. any governmental law or program that provides disability benefits as a result of Your job with the Employer;
4. salary continuation or sick pay;
5. the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;
6. any temporary disability benefits under a workers' compensation law, occupational disease law, or similar law.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

Any general increase in benefits required by law that You are entitled to receive under any Federal Law will not reduce the Long Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If You are paid Other Income Benefits in a lump sum, We will pro rate the lump sum:
1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined over a period of 24 months.

We may require:
1. Your signed statement identifying all Other Income Benefits; and
2. proof that You have duly applied for all Other Income Benefits We reasonably believe You are entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

You will be required to apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You will be required to apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:
1) to follow the process established by the Social Security Administration to reconsider the denial; and

2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals if such action can reasonably be expected to result in an award.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence.

If Your disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

We will use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Monthly Benefit payable under this plan even if You are not receiving these benefits.

We will use any reasonable means to estimate the amount of temporary disability benefits payable to You under a workers compensation law or any other occupational disease law or similar act; or the amount of benefits payable to You under any statutory benefit law, plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of these benefits from Your Monthly Benefit payable under this plan even if You are not receiving these benefits.

Physician means a person who is:
1. a doctor of medicine, osteopathy, psychology or other healing art recognized by us;
2. licensed to practice in the state or jurisdiction where care is being given; and
3. practicing within the scope of that license.

Pre-disability Earnings means your Monthly Rate of Basic Earnings in effect on the day before you became Disabled.

Prior Plan means the long term disability insurance carried by the Employer on the day before the Plan Effective Date.

Regular Care of a Physician means you are attended by a Physician, who is not related to you:
1. with medical training and clinical experience suitable to treat your disabling condition; and
2. whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research and rehabilitative organizations; and
   c) administered as often as needed,

to achieve the maximum medical improvement.

Partial Disability or Partially Disabled means You are not Totally Disabled, and while actually working in an occupation, as a result of sickness or injury, You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience or station in life, and physical and mental capacity.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan or 403(b) plan.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means as a result of injury or sickness, You are unable to engage with reasonable continuity in Any Occupation in which you could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

We, us or **our** means the Hartford Life and Accident Insurance Company.

You, your, Insured Person means the Insured Person to whom this Booklet-certificate is issued.

STATUTORY PROVISIONS

ILLINOIS

SHORT TERM DISABILITY

The following is applicable to residents of Illinois to bring Your Booklet-certificate into conformity with Illinois state law.

All certificates are hereby amended by the deletion of the Policy Interpretation provision appearing in the General Provisions section of the Short Term Disability portion of the certificate, in its entirety, and all reference thereto.

LONG TERM DISABILITY

The following is applicable to residents of Illinois to bring Your Booklet-certificate into conformity with Illinois state law.

All certificates are hereby amended by the deletion of the Policy Interpretation provision appearing in the General Provisions section of the Long Term Disability portion of the certificate, in its entirety, and all reference thereto.

KANSAS

SHORT TERM DISABILITY

The following provision is applicable to residents of Kansas and is included to bring your Booklet-certificate into conformity with Kansas state law.

Subrogation

The provision entitled "What are your subrogation provision rights?" is deleted and does not apply to you.

NEW HAMPSHIRE

SHORT TERM DISABILITY

The following provision is applicable to residents of New Hampshire and is included to bring your Booklet-certificate into conformity with New Hampshire state law.

Where to Call for Information Regarding a Claim

If you have a question regarding a claim, you or the policyholder may call Hartford Life at 1-800-752-9713. When calling, please give us the following information:

(1) the policy number; and
(2) the name of the policyholder (employer or organization) as shown in this Booklet-certificate.

This notice is for your information only and does not become a condition of this Booklet-certificate.

LONG TERM DISABILITY

The following provision is applicable to residents of New Hampshire and is included to bring your Booklet-certificate into conformity with New Hampshire state law.

If you have a question regarding a claim, you or the policyholder may call Hartford Life at 1-800-752-9713. When calling, please give us the following information:
1. the policy number; and
2. the name of the policyholder (employer or organization) as shown in this Booklet-certificate.

This notice is for your information only and does not become a condition of this Booklet-certificate.

NEW JERSEY

LONG TERM DISABILITY

The following provision is applicable to residents of New Jersey and is included to bring your Booklet-certificate into conformity with New Jersey state law.

Subrogation

The provision entitled "What are our subrogation rights" appearing in the General Provisions section of your Booklet-certificate does not apply to you.

NEW YORK

SHORT TERM DISABILITY

The following provision is applicable to residents of New York and is included to bring your Booklet-certificate into conformity with New York state law**.**

Subrogation

The provision entitled "What are our subrogation rights?" is deleted.

LONG TERM DISABILITY

The following provisions are applicable to residents of New York and are included to bring your Booklet-certificate into conformity with New York state law.

1. Pre-existing Conditions Limitations

The following provision is added to the paragraph entitled “Are there any other limitations on coverage?” in the Pre-existing Conditions Limitations section appearing in your booklet.

However, if you become insured under the Group Insurance Policy and were covered under a group or blanket disability insurance plan or employer-provided disability benefit arrangement within 60 days of your effective date of coverage under this plan, any:
1. treatment-free period requirements; or
2. period of coverage requirements,

which were satisfied or partially satisfied under your previous coverage will be credited toward satisfaction of similar periods under this plan.

2. Continuity From a Prior Plan

The section entitled "Continuity From a Prior Plan" is amended to read as follows:

Is there continuity of coverage from a Prior Plan?
If you were:
1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

If you were covered under a Prior Plan within 60 days prior to the date your coverage under this plan takes effect, the Pre-Existing Conditions Limitation will cease to apply on the first to occur of the following dates:
1. the date your coverage under the plan takes effect, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the previous paragraph will be the lesser of:
1. the Monthly Benefit which was paid by the Prior Plan; or
2. the Monthly Benefit provided by this plan.

No payment shall be made after the earlier to occur of:
1. the date payments would have ceased under the Prior Plan; or
2. the date payments cease under this plan.

If you received Monthly Benefits for Disability under the Prior Plan, and:
1. you returned to work as an Active Full-time employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

Prior Plan, for the purpose of this provision, means an employer-provided disability benefit arrangement or group or blanket long term disability insurance carried by the Employer on the day before the Plan Effective Date.

OKLAHOMA

LONG TERM DISABILITY

The following provision is applicable to residents of Oklahoma and is included to bring your Booklet-certificate into conformity with Oklahoma state law.

Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

TEXAS

SHORT TERM DISABILITY

The following provisions are applicable to residents of Texas and are included to bring your Booklet-certificate into conformity with Texas state law**.**

1. Workers' Compensation Notice

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

2. Insurer Information Notice

IMPORTANT NOTICE	**AVISO IMPORTANTE**
To obtain information or make a Complaint:	**Para Obtener Informacion O Para Someter Una Queja:**
You may call Hartford Life's toll-free telephone number for information or to make a complaint at:	Usted puede llamar al numero de telefono gratis de Hartford's para informacion o para de someter una queja al:
1-800-752-9713 if about a claim **1-800-523-2233 if not about a claim**	**1-800-752-9713 ascerca de un reclamo** **1-800-523-2233 para una queja**
You may also write to Hartford Life P.O. Box 2999 Hartford, CT 06104-2999	Usted tambien puede escribir a Hartford P.O. Box 2999 Hartford, CT 06104-2999
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:	Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias coberturas, derechos o quejas al:
1-800-252-3439	**1-800-252-3439**
You may write the Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104	Puede escribir al Departamento de Seguros de Texas P.O. Box 149104 Austin, TX 78714-9104

FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Hartford Life first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo debe comunicarse con el (la compania) Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

LONG TERM DISABILITY

The following provisions are applicable to residents of Texas and are included to bring your Booklet-certificate into conformity with Texas state law**.**

1. Workers' Compensation Notice

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

2. Insurer Information Notice

IMPORTANT NOTICE	**AVISO IMPORTANTE**
To obtain information or make a Complaint:	**Para Obtener Informacion O Para Someter Una Queja:**
You may call Hartford Life's toll-free telephone number for information or to make a complaint at:	Usted puede llamar al numero de telefono gratis de Hartford's para informacion o para de someter una queja al:
1-800-752-9713 if about a claim **1-800-523-2233 if not about a claim**	**1-800-752-9713 ascerca de un reclamo** **1-800-523-2233 para una queja**
You may also write to Hartford Life P.O. Box 2999 Hartford, CT 06104-2999	Usted tambien puede escribir a Hartford P.O. Box 2999 Hartford, CT 06104-2999
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:	Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias coberturas, derechos o quejas al:
1-800-252-3439	**1-800-252-3439**
You may write the Texas Department of Insurance P.O. Box 149104	Puede escribir al Departamento de Seguros de Texas P.O. Box 149104

Austin, TX 78714-9104
FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Hartford Life first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

Austin, TX 78714-9104
FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo debe comunicarse con el (la compania) Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

UTAH

SHORT TERM DISABILITY

The following provision is applicable to residents of Utah and is included to bring your Booklet-certificate into conformity with Utah state law.

Interpretation of Policy Terms and Conditions

The following provision is deleted:

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

LONG TERM DISABILITY

The following provision is applicable to residents of Utah and is included to bring your Booklet-certificate into conformity with Utah state law.

Interpretation of Policy Terms and Conditions

The following provision is deleted:

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

VIRGINIA

SHORT TERM DISABILITY

The following provision is applicable to residents of Virginia and is included to bring your Booklet-certificate into conformity with Virginia state law.

Subrogation

The provision entitled "What are our subrogation rights?" is deleted and does not apply to you

LONG TERM DISABILITY

The following provision is applicable to residents of Virginia and is included to bring your Booklet-certificate into conformity with Virginia state law.

Subrogation

The provision entitled "What are our subrogation rights?" appearing in the General Provisions section of your Booklet-certificate does not apply to you.

WISCONSIN

SHORT TERM DISABILITY

The following provision is applicable to residents of Wisconsin and is included to bring your Booklet-certificate into conformity with Wisconsin state law.

Subrogation

The subrogation provision appearing in your Booklet-certificate is deleted and replaced with the following.

What are our subrogation rights?
If you:
1. suffer a Disability because of the act or omission of a third party;
2. become entitled to and are paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights you may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability. Such right may be exercised only if you have been, or will be, fully compensated for the lost wages.

LONG TERM DISABILITY

The following provision is applicable to residents of Wisconsin and is included to bring your Booklet-certificate into conformity with Wisconsin state law.

Subrogation

The following provision replaces the provision of the same title appearing in the General Provisions section of your Booklet-certificate.

What are our subrogation rights?
If an Insured Person:

1. suffers a Disability because of the act or omission of a third party;
2. becomes entitled to and is paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. does not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights the Insured Person may have against the third party and may, at its option, bring legal action to recover any payments made by it in connection with the Disability. Such right may be exercised only if the Insured Person has been, or will be, fully compensated for the lost wages.

ERISA INFORMATION

THE FOLLOWING NOTICE CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

1. **Plan Name**

   LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES.

2. **Plan Number**

   STD - 501

   LTD - 501

3. **Employer/Plan Sponsor**

   LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES
   7000 East Avenue
   Livermore, CA 94551

4. **Employer Identification Number**

   20-5624386

5. **Type of Plan**

   LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES.

6. **Plan Administrator**

   LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES
   7000 East Avenue
   Livermore, CA 94551

7. **Agent for Service of Legal Process**

For the Plan

LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES
7000 East Avenue
Livermore, CA 94551

For the Policy:

Hartford Life And Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet

is Insured by the

Hartford Life and Accident Insurance Company

Hartford, Connecticut

Member of The Hartford Insurance Group